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TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Partial Hospitalization	OMH will establish regional fee schedules which recognize regional cost differences. All fees are subject to approval by the Division of the Budget. There will be limits on the number of service hours reimbursed per individual for each service episode and for a calendar year.
Comprehensive Outpatient Programs - 14 NYCRR Part 592	OMH will develop provider specific rate supplements to fees [detailed in 14 NYCRR Parts 579 and 588] <u>for outpatient mental health programs licensed exclusively by OMH and rates promulgated by OMH for outpatient mental health programs operated by general hospitals and licensed by OMH</u> based upon expenditures approved by OMH to outpatient programs licensed pursuant to 14 NYCRR Parts 585 and 587 [who] <u>which</u> are designated by county mental health departments or OMH.

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TYPE OF SERVICE	
Intensive Psychiatric Rehabilitation Treatment	OMH will develop a flat fee to be approved by the Division of Budget. There will be limits on the number of monthly and calendar year service hours that may be reimbursed per individual. Off-site service reimbursement will all be limited to a percentage of each program's total service hours.
Rehabilitative Services for Residents of Community-based Residential Programs Licensed by the Office of Mental Health Program Type 1: 1) Community Residences Program Categories a) congregate-type b) apartment-based Program Type 2: 1) Family Based Treatment Program Type 3: 1) Teaching Family Homes	OMH will develop monthly and half-monthly rates for OMH licensed community-based residences of sixteen (16) or fewer beds to provide physician-prescribed rehabilitation services for seriously mentally ill individuals in residences. OMH will develop rates for services provided to eligible residents of congregate-type community residences for both children and adults, apartment-based community residences for adults, family-based treatment programs for children and teaching family homes for children. Rehabilitation services will not include didactic education, vocational services, and room and board. Providers of rehabilitation services shall be assigned an individual provider monthly rate based upon their cumulative approved costs for all sites divided by the maximum capacity for their sites divided by 12 months, divided by the specific utilization factor established by the Office of Mental Health for beds in adult congregate programs (85%), adult apartment programs (83%) or for children's residential services programs (82%). Rates for a half month service shall be 50% of the monthly rate. The rate calculated under this methodology will be reduced by $4 for a full month and $2 for a half month rate to account for payment for the four individual Rehabilitation Services at a cost of $1.00 per service required for a full month and two individual Rehabilitation Services at a cost of $1.00 per service required for a half month. The rate methodology for rehabilitation services provided in residential programs operated by the Office of Mental Health shall be the same as for other licensed providers except that there shall be one statewide rate which shall be the lower of the calculated rate or the highest rate approved for other providers.

Attachment 4.19B
SPA 95-25

Laboratory Services

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended, or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen hundred ninety-five through December 31, 1995 and for rate periods beginning on or after January 1, 1996, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. The amount of such reduction in certified home health agency rates of payments made during the period April 1, 1995 through March 31, 1996 shall be adjusted in the 1996 rate period on a pro-rata basis, if it is determined upon post-audit review by June 15, 1996 and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars or is less than one million five hundred thousand dollars for payments made on or before March 31, 1996, to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars.

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In addition, [illegible]

[illegible] provided to patients diagnosed with Acquired Immune Deficiency Syndrome (AIDS) shall be established based upon regional services prices. Such prices shall be computed based upon average nursing costs per visit calculated by aggregating base year allowable costs and statistics reported by certified home health agencies within each of four state regions, and increased by a case mix adjustment factor which represents the relative ratio of additional resources needed to provide home care nursing services to AIDS patients when compared to the average case mix of home care patients. Such AIDS regional nursing prices will be trended annually.

TN 92-25 [illegible] SEP 17 1992

Supersedes TN 90-45 [illegible] Date APR 1 1992

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4(a)(i)

Attachment 4.19B
Part I

Reimbursement for Personal Emergency Response Services (PERS) will be provided under the auspices of SDSS through contractual arrangements between the LDSS and the provider. Locally negotiated rates must include the costs for renting or leasing PERS equipment, the installation, maintenance, and the removal of PERS equipment from the client's home. A second rate must also be negotiated by the local district for a monthly monitoring service charge. These two rates must not exceed the local prevailing rate or the SDSS established cap.

For the period April 1, 1995 through March 31, 1996, the Department of Social Services in consultation with the Department of Health shall establish a state share medical assistance cost savings target for each certified home health agency, which is to be achieved as a result of the agency's development and implementation of personal emergency response services and shared aide efficiency initiatives. The aggregate of such state share targets shall not exceed fifteen million five hundred thousand dollars.

The Department of Health shall calculate an adjustment to the approved rate of payment for the period July 1, 1995 to December 31, 1995 for each such agency by an amount sufficient to achieve its agency-specific savings target, as established by the Department of Social Services, prior to March 31, 1996. Such adjustment shall not be considered a rate change or rate adjustment, but shall serve as an offset of payments to the agency against its liability to the state for savings to be achieved under its agency-specific target, as established by the Department of Social Services.

On or before January 1, 1996 the Department of Social Services shall notify agencies of the progress made toward reaching the specific targets, including information on the number of new clients being

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served, the types of services provided, and the amount of any state funds which have been offset from their rates and applied to the agency target. Any agency that believes that the offset of its payments was incorrect may request the Commissioner of the Department of Social Services to review its payments by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, the Commissioner of the Department of Social Services finds that the payments were incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any amount incorrectly offset, as soon as possible, but in no event later than June 30, 1996.

As soon as practicable after March 31, 1996, the Commissioner of Social Services shall review the total payments made to each such agency; the amount of the offset from payments otherwise due the agency; and the total savings actually achieved by the agency as a result of the agency's development and implementation of personal emergency response systems and shared aide efficiencies initiatives. If the Commissioner of Social Services determines that payments to any agency were offset in an amount greater than was necessary to meet its agency-specific savings target given the agency's actual savings achieved, the Commissioner of Social Services shall authorize payment of such amount to such agency, as soon as possible, but in no event later than June 30, 1996. Any agency dissatisfied with the determination of the Commissioner of Social Services may request the Commissioner of Social Services to review its payments, offsets and savings achieved by filing a written request for review with such Commissioner within ten days of receipt of such notice. If, after reviewing the determination, such Commissioner finds that the determination was incorrect, such Commissioner shall determine the amount of the payments to be restored, if any, and authorize the payment of any amount incorrectly offset, as soon as possible, but in no event later than September 30, 1996.

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Effective for the period August 1, 1996 through March 31, 1997, certified home health agencies (CHHAs) shall be required to increase their Medicare revenues relative to their Medicaid revenues measured from a base period (calendar year 1995) to a target period (August 1, 1996 to March 31, 1997) or receive a reduction in their Medicaid payments. For this purpose, regions shall consist of a downstate region comprised of Kings, New York, Richmond, Queens, Bronx, Nassau and Suffolk counties and an upstate region comprised of all other New York State counties. A certified home health agency shall be located in the same county utilized by the commissioner of health for the establishment of rates pursuant to article 36 of the public health law. Regional group shall mean all those CHHAs located within a region. Medicaid revenue percentage shall mean CHHA revenues attributable to services provided to persons eligible for payments pursuant to title 11 of article 5 of the social services law divided by such revenues plus CHHA revenues attributable to services provided to beneficiaries of Title XVIII of the federal social security act (Medicare).

Prior to February 1, 1997, for each regional group, 1996 Medicaid revenue percentages for the period commencing August 1, 1996 to the last date for which such data is available and reasonably accurate shall be calculated. By September 15, 1996, for each regional group, the base period Medicaid revenue percentage shall be calculated. For each regional group, the 1996 target Medicaid revenue percentage shall be calculated as the result of subtracting the Medicaid revenue reduction percentages from the base period Medicaid revenue percentages. The Medicaid revenue reduction percentage, taking into account regional and program differences in utilization of Medicaid and Medicare services, for the following regional groups shall be equal to:

one and one-tenth percentage points for CHHAs located within the downstate region; and

six-tenths of one percentage point for CHHAs located within the upstate region.

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4 (a)(iv)

For each regional group, if the 1996 Medicaid revenue percentage is not equal to or less than the 1996 target Medicaid revenue percentage, a 1996 reduction factor shall be calculated by comparing the 1996 Medicaid revenue percentage to the 1996 target Medicaid revenue percentage to determine the amount of the shortfall and dividing such shortfall by the Medicaid revenue reduction percentage. These amounts, expressed as a percentage, shall not exceed one hundred percent. If the 1996 Medicaid revenue percentage is equal to or less than 1996 target Medicaid revenue percentage, the 1996 reduction factor shall be zero. For each regional group, the 1996 reduction factor shall be multiplied by the following amounts to determine each regional group's applicable 1996 state share reduction amount:

two million three hundred ninety thousand dollars ($2,390,000) for CHHAs located within the downstate region;

seven hundred fifty thousand dollars ($750,000) for CHHAs located within the upstate region.

For each regional group reduction, if the 1996 reduction factor shall be zero, there shall be no 1996 state share reduction amount.

For each regional group, the 1996 state share reduction amount shall be allocated among CHHAs on the basis of the extent of each CHHAs failure to achieve the 1996 target Medicaid revenue percentage, calculated on a provider specific basis utilizing revenues for this purpose, expressed as a proportion of the total of each CHHAs failure to achieve the 1996 target Medicaid revenue percentage within the applicable regional group. This proportion shall be multiplied by the applicable 1996 state share reduction amount. This amount shall be called the 1996 provider specific state share reduction amount.

The 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped by the state by March 31, 1997 in a lump sum amount or amounts from payments due to the CHHA pursuant to title 11 of article 5 of the social services law. CHHAs shall submit such data and information at such times as the commissioner of health may require. The commissioner of health may use data available from third party payors.

On or about June 1, 1997, for each regional group the commissioner of health shall calculate for the period August 1, 1996 through March 31, 1997 a Medicaid revenue percentage, a reduction factor, a state share reduction amount, and a provider

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specific state share reduction amount in accordance with the methodology provided herein. The provider specific state share reduction amount calculated shall be compared to the 1996 provider specific state share reduction amount. Any amount in excess of the 1996 provider specific state share reduction amount shall be due to the state from each CHHA and may be recouped. If the amount is less than the 1996 reduction amount, the difference shall be refunded to the CHHA by the state no later than July 15, 1997. CHHAs shall submit data for the period August 1, 1996 through March 31, 1997 to the commissioner of health by April 15, 1997. If a CHHA fails to submit data and information as required, such CHHA shall be presumed to have no decrease in Medicaid revenue percentage between the base period and the target period for purposes of the calculations described herein and the commissioner of health shall reduce the current rate paid to such CHHA by state governmental agencies pursuant to article 36 of the public health law by one percent for the period beginning on the first day of the calendar month following the due date as established by the commissioner of health and continuing until the last day of the calendar month in which the required data and information are submitted.

TN 96-35

Supersedes New

Date OCT 22 1996

AUG 01 1996

**Home Health Services
Community and Residential Based
Certified Home Health Agencies
Under Article 36 of the Public
Health Law**

An allowance will be established annually and added to Medicaid rates of payment for certified agencies which can demonstrate a financial shortfall as a result of providing services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publically-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies.

[~~For purposes of establishing rates of payment by governmental agencies for certified home health agencies for rate the periods beginning on or~~]

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